FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

*Section 67 of the **Coroners Act 2008***

Court reference: 5119/07

Inquest into the Death of LISA IRENE SHARP

Delivered On:	16th August 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Dates:	16th August 2011
Findings of:	CORONER HEATHER SPOONER
Representation:	
Place of death:	10 Kathy Court, Mooroolbark, Victoria 3138
PCSU:	Leading Senior Constable King Taylor

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 5119/07

In the Coroners Court of Victoria at Melbourne

I, HEATHER SPOONER, Coroner

having investigated the death of:

Details of deceased:

Surname: SHARP
First name: LISA
Address: 10 Kathy Court, Mooroolbark, Victoria 3138

AND having held an inquest in relation to this death on 16th August 2011
at Melbourne

find that the identity of the deceased was LISA IRENE SHARP
and death occurred between 16th December, 2007 and 17th December, 2007

at 10 Kathy Court, Mooroolbark, Victoria 3138

from
1a. HANGING
2. COMBINED EFFECTS OF ETHANOL AND BENZODIAZEPINES

In the following circumstances:

1. Ms Sharp was aged 34 when she died. She lived at 10 Kathy Court, Mooroolbark with her partner Mr Craig Dunbar. Her three children lived elsewhere with their father. Ms Sharp had a medical history that included depression, schizophrenia, panic attacks, post traumatic stress disorder, anxiety, drug and alcohol abuse, drug related psychosis and previous suicide attempts. She was subject to a Community Treatment Order (CTO) at the time of her death.

Brief circumstances surrounding death

2. A police investigation was conducted. It was apparent that Ms Sharp was very distressed about the custody of her children and a Children's Court Hearing on 14 December, 2007.

3. On Saturday 15 December 2007 at about 10.45am, police were called to her home by Mr Dunbar as she had threatened to hang herself. They threw an extension cord that she had used in the bin. The Metropolitan Ambulance Service attended and conveyed Ms Sharp to Maroondah Hospital for psychiatric assessment.

4. A few hours later, she was released from hospital and returned home. According to Mr Dunbar, Ms Sharp was still depressed when she returned from hospital.

5. On Sunday 17 December 2007 at about 1.00am, Mr Dunbar checked her room and when he could not locate Ms Sharp, he assumed she had gone to visit a nearby friend.

6. At about 8.00am when Ms Sharp was still not home he checked the bin. Mr Dunbar found that the rope was missing so he looked further until locating her in the backyard shed.

7. Emergency services were notified and attended, but Ms Sharp had died.

8. An Inquest was convened to obtain more evidence about the surrounding circumstances including Ms Sharp's care and treatment under her CTO, the police attendance at her home and Ms Sharp's presentation, assessment and discharge from Maroondah Hospital on the day prior to her death.

Evidence at Inquest

9. Mr Craig Dunbar told the Inquest that although he had known Ms Sharp for about 15 months, they had only lived together for a couple of months prior to her death. He spoke of her depression over the children she loved and her worry over how to get them back. She was constantly crying, drinking and chain smoking. The alcohol made her worse. He recalled another earlier attempted self-harm incident and indicated how her behaviour made him weary and tired. He tried to restrict her alcohol intake. Mr Dunbar only had a limited awareness of the Children's Court hearing in the days before her death although he had a meeting with a *'couple of ladies including her case manager, Angela'*. He had spoken privately to Angela about his concerns for Ms Sharp's welfare. On the evening of 16 December 2007, when Ms Sharp returned in a quiet state from hospital, he asked her to relax. He was *'burnt out'* by her behaviour and needed some peace and sleep. He had no idea that she was planning to take her life and was shocked to find her the following morning.

10. Ms Angela Ballis (now Edmonds) was the registered psychiatric nurse and case worker for Ms Sharp. She had known her for many years and was aware of a past suicide attempt in 2002. Her role included giving prescribed medication and organising any supports that may be needed for her mental health. Ms Ballis had arranged for Ms Sharp to be seen by a psychiatrist on 10 December 2007, as she believed Ms Sharp had been *'doctor shopping'*. She felt this

needed to be formally addressed at a formal review so that a letter could be sent to the Childrens Court.

11. According to Ms Ballis, she was a *'big psychological support'* in Ms Sharp's attempt to get her children back and the question of child custody was a major issue in her life. Although Ms Sharp loved her children, she apparently struggled to cope.

12. There were insufficient resources for anyone to attend the court case with Ms Sharp on 14 December 2007, although in hindsight Ms Ballis agreed it could have occurred and would have been reasonable, particularly as the material being placed before the court was unfavourable to Ms Sharp.

13. There had been no follow-up after the court case as Ms Ballis was away from work until 17 December 2007. She was aware that the court case was a major stressor for Ms Sharp and that she appeared to be crumbling under the pressure. Ms Ballis was disappointed that Ms Sharp had taken her life as she was driven by her children and her hopes for reunification with them.

14 When asked about Ms Sharp's suicide risk, Ms Ballis told the inquest that despite her poor coping skills, low tolerance and threat of losing custody of the children, she did not think that Ms Sharp would harm herself for the sake of her children. She did not recall Mr Dunbar mentioning any incident of self-harm. Ms Ballis had not been notified when Ms Sharp attended Maroondah Hospital and would not have expected that to occur.

15. Mr Gary Cox was the psychiatric nurse who saw Ms Sharp approximately four hours after her ambulance transfer to Maroondah Hospital. He knew Ms Sharp from previous occasions and an emergency presentation. On this occasion, he was approached by Dr Cremin who had seen Ms Sharp in the Emergency Department, with a request that he see her.

16. The doctor's notes indicated that she was suicidal with no plan and a question mark about intent. When Mr Cox directly asked Ms Sharp about her saying that she was suicidal, Ms Sharp said that she was not suicidal but would be if she did not get drugs that she was seeking. This was not regarded as a threat but *'part of the negotiation pattern people use.'* He reported that Ms Sharp had a history of seeking *'benzos'* and making threats, which had not been carried out in the past. He felt that he had a *'good picture'* in not allowing *'benzos'* and allowing her to go. He did not think there was any *'real'* risk of her taking her life and he felt her responses gave no major concerns at the time and were consistent with the recent notes in her file.

17. Mr Cox did not identify any acute issues and it was his view that the custody issues Ms Sharp had raised with the doctor and triage nurse had been present for some time. His concern was that given her *'benzos'* had been restricted, she was suffering withdrawal but not agitated.

He considered getting her some valium but she indicated that she had some at home. Ms Sharp was sent on her way without further assistance.

18. The notes of Mr Cox were brief and not the usual several page assessment. Apparently at that time, they were in the process of going electronic. Mr Cox had Ms Sharp's file and as she had been last seen within three months, the general rule was that a full assessment was unnecessary.

19. Mr Cox had not seen the ambulance notes and he did not seek them, as he felt that he had sufficient information on why Ms Sharp was presenting. He was unaware of the police attendance or that there had been a court hearing just days before. He may have contacted the police if aware of their involvement. Mr Cox believed he had sufficiently acquainted himself with Ms Sharp's concerns by reading her file, having a handover and looking at the presenting problems.

Submissions on behalf of Eastern Health

20. It was submitted that Ms Sharp's death was tragic but unforeseeable; Mr Cox was a senior psychiatric nurse who had a significant amount of background information. He had received a verbal handover and had personal contact just three weeks before when Ms Sharp had been admitted to hospital. Although he was not appraised of the circumstances of her coming to hospital, Ms Sharp had appeared calm, not distressed and he tried to assist her. He knew that she had seen her case manager and psychiatrist the week prior and in his view her suicide risk was low. It was submitted that even if he had obtained the ambulance records, her answers may not have changed his view.

Comments and Conclusions arising from the investigation and evidence

21. It was apparent that Ms Ballis was Ms Sharp's case manager leading up to her death. The Murnong Clinic recorded in the medical records over many years of involvement with Ms Sharp that she was at increased risk of impulsive self-harm, when she was stressed, and self-medicating her anxiety with alcohol, benzodiazepines and over-the-counter medications. According to Ms Sharp's partner, he had spoken to Ms Ballis and verified Ms Sharp's clinical deterioration.

22. The Murnong Clinic staff were aware of the major stressor in Ms Sharp's life, the loss of custody of her children, to the point where a letter from Murnong Clinic to the Department of Human Services, Child Protection, clearly advised against Ms Sharp gaining custody of her children. The letter composed and signed by Ms Ballis, Dr C Fairhall (Registrar) and Dr L Thorley (Consultant Psychiatrist) dated 13 December 2007 to Department of Human Services, Child Protection gave the reason why Lisa Sharp should not have custody of her children as:

She had been actively seeking Diazepam and has continued to present as highly anxious, but guarded denying current alcohol abuse however admitted same under pressure in interview. She had admitted to past 3 weeks alcohol abuse however we believe it to be more like 12 weeks. This period is consistent with Lisa's deterioration in mental state with increased disorganised behaviour and seeking Diazepam also commencement of relationship with new partner Craig.

Lisa is known to love and care for her children deeply, but her ability to care for them is compromised by the following:

- *Disorganised, chaotic and forgetful behaviours;*
- *Chaotic binge pattern of alcohol and Benzodiazepine abuse/addiction;*
- *Anxiety/panic attacks;*
- *Poor budgeting and planning often requiring food parcels; and*
- *Poor engagement or willingness to attend programs to develop skills.*

23. In her statement, Ms Ballis indicated that Lisa's *panic/anxiety attacks render her unable to care for her children.* This view of the mental state and functional capacity of Ms Sharp was written 4 days before her death and provides a picture of a woman who was not coping and who required assertive follow-up from her treating mental health team. The court case for custody of her children, to which the letter pertained, was scheduled for 14 December 2007 and Ms Ballis recognised it as a major stressor in Ms Sharp's life. Although Ms Bayliss may have been away, it is unclear what led the treating team to have no planned or actual contact with Ms Sharp on the day of or after the court case.

24. A statement in the file by Ms Ballis, dated 17 December 2007, revealed the court case did not go ahead because the solicitor could not find Ms Sharp. Given the degree of disorganisation reported by the Murnong Clinic, and the record of Ms Sharp's history of unreliability in attending appointments, it is surprising Murnong Clinic did not arrange or offer to arrange transport for or to have considered escorting Ms Sharp to this important appointment. Ms Ballis and the treating team's direct contact with Ms Sharp ceased on 10 December 2007 when they changed the treatment plan to restrict Ms Sharp's access to Benzodiazepines. Ms Sharp's daily pickup of Diazepam 10mgs was for 7 days only and ceased on 17 December 2007. There was no evidence in the medical file or the statements of involved clinicians that there was any plan by the team to reassess the effectiveness of this change in treatment or if Ms Sharp was coping leading up to the cessation of the Diazepam order.

25. It was apparent that upon transporting Ms Sharp by ambulance to the Maroondah Hospital the paramedics communicated with the Emergency Department Triage Clinician, Ms Sonja Laukart. The MH/162 Emergency Management Form completed by Ms Laukart, states recent stressors, now suicidal, depressed, anxiety, wants help, previous psych Hx. In conjunction with

the Ambulance Victoria Electronic Patient Care Report (VACIS), it was clear Ms Sharp had very recently attempted to hang herself. It was not clear if this information had been verbally communicated in the handover to Ms Laukart but this information does not appear to translate to any of the Maroondah Hospital clinical documentation. The inclusion of this information may have decreased the degree of focus on Ms Sharp's request for benzodiazepines and resulted in the assessment of her mental state and risk.

26. The Ambulance Victoria VACIS however did state:

> *Anxiety; depression; suicidal >> ATTEMPTED HANGING 2/7*

And

> *Pt 34 YO Female. Recent family problems with children custody issues. Increased depression/anxiety suicidal attempt 2/7 by hanging. This PM Pt at home with partner acopia. Anxious+++. MAS called.*

27. Ms Sharp was on a CTO and the decision made by Victoria Police to offer her assessment and voluntary transport by Ambulance Victoria to an emergency department for assessment was the least restrictive approach. The information provided in both Dr Cremin (Emergency Department Medical Officer) and the Ambulance Victoria VACIS form would hopefully have been sufficient for Mr Cox (Registered Nurse) to complete further enquires to enable an informed risk assessment.

28. The inclusion of handover information with a copy of VACIS included in the medical file is not uncommon.[1] The onus was apparently on the clinical staff to clarify and check all available information. Ms Laukart triaged Ms Sharp as a category 3, requiring a response in 30 minutes. Dr Cremin did see Ms Sharp within 30 minutes and made a referral to mental health but it appears to have then taken another 4 hours for Ms Sharp to be assessed.

29. Mr Cox was apparently aware Ms Sharp was transported to Maroondah Hospital because she had been '*claiming*' she was suicidal however he appeared to be unaware of her recent

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[1] In reply to a request from the Coroner about the process for handling ambulance reports in the Emergency Department (ED), Ms Whitty Legal Counsel for Eastern Health wrote:

a) As soon as possible, upon arrival in ED, ambulance officers physically transfer the patient to the care of the hospital and provide a complete verbal handover to the triage nurse in ED. The triage nurse types up the triage notes based on the verbal handover from the ambulance officers.
b) Following the transfer and handover of the patient, the ambulance officers usually type up their report while still at the hospital, and the completed report is placed in a tray in ED. Occasionally, ambulance officers are required to leave the hospital to attend to another case before the report can be prepared, and in those cases they type up their report at a later time and then provide it to the hospital. It is expected that the information in the report is the same as the verbal handover.
c) Clerks in ED are expected to take the report to where the patient is located (for example, in a cubicle).

attempts at hanging. He seemed to have responded to her as a patient presenting for the purpose of doctor shopping for benzodiazepines and recorded that as the presenting problem. He did not appear to have incorporated the collateral information available to him including Dr Cremin's assessment some four hours earlier or the ambulance transfer record which clearly records Ms Sharp was transported by Ambulance Victoria following *anxiety; depression; suicidal >> ATTEMPTED HANGING 2/7,* which should have expanded his knowledge of what had led to Ambulance Victoria transporting Ms Sharp for assessment.

30. Ms Sharp's presentation on 15 December 2007 should have resulted in a mental state examination and risk assessment irrespective of whether a full psychosocial and psychiatric assessment by a member Eastern Health Mental Health Services had been performed within the previous three months. Mr Cox recorded that Lisa does have a history of suicidal behaviour and is a risk of impulsive behaviour but did not complete a mental state examination or risk assessment.

31. Mr Cox recorded Ms Sharp had *complained of anxiety but did not appear restless or highly agitated.* He reviewed her file before seeing her. The medical records clearly listed panic and anxiety as problems for Ms Sharp. Her history of anxiety and case manager identification of self-medication with alcohol and benzodiazepines, combined with life stressors including the loss of custody of her children and recent changes in treatment (especially the restriction of access to benzodiazepines which were taken to allay Ms Sharp's anxiety) created significant risk factors. Dr Rebecca Marsden's (Emergency Department Emergency Physician) statement given in the absence of Dr Cremin stated Ms Sharp had a decreased affect, low mood and decreased rapport and eye contact. Mr Cox did not describe Ms Sharp's presentation in the clinical documentation.

32. It was not apparent that Murnong Clinic reacted to faxed information from Mr Cox, which he sent after seeing her, in that there was no further contact with Ms Sharp. Mr Cox's discharge plan was for Ms Sharp to make contact with her case manager to discuss medication requirements. Given Ms Sharp's current level of disorganisation and known, long-standing issues with attending appointments, it was an inadequate response.

33. The Department of Health 2010 document *Working with the suicidal person Clinical practice guidelines for emergency departments and mental health services*[2] summary of recommendations cites the main principles for staff to consider in the assessment and management of people at risk of suicide. They are information gathering, thorough assessment, secondary consultation/debriefing/supervision, and decision making that is clear and communicated to those involved. The suggested outcomes to an assessment are:

[2] Victorian Government, Department of Health, Mental Health, Drugs & Regions branch, 2010 Working with the suicidal person Clinical practice guidelines for emergency departments and mental health services Melbourne, Victoria.

- A follow-up plan documented and communicated to the person and significant others;

- If a person is currently known to mental health services, inform the relevant team of their attendance; and

- Mental health team follow up all people within 48 hours of discharge, where possible.

34. It was apparent that Mr Cox did not formally assess the mental state or risk of self-harm of Ms Sharp and consequently did not develop a plan. Mr Cox reviewed Ms Sharp's file before seeing her and during this review, it should have been clear to Mr Cox that Murnong Clinic considered Ms Sharp's disorganisation, unreliability, current treatment of comorbid anxiety and current social and personal vulnerabilities as serious. Mr Cox was aware Ambulance Victoria transported Ms Sharp to the Emergency Department and it is clear he was aware she did not have transport home.

35. The statements of Mr Cox and Dr Marsden clearly record Ms Sharp as saying she will *become* suicidal at home without this [benzodiazepines]. It was not clear if this was a statement of fact by Ms Sharp or, as interpreted by the clinicians' involved, a threat aimed at obtaining benzodiazepines. Mr Cox stated *my impression was that Lisa was seeking benzodiazepines to abuse.* Given that Benzodiazepines were a recognised treatment option for anxiety and Murnong Clinic had been prescribing a regime to treat Ms Sharp's anxiety, it was surprising Mr Cox made no effort to contact Ms Sharp's partner or other support persons regarding her safety and arrangements for transport home.

36. In Dr Cremin's notes in the Emergency Department record, it stated that [Ms Sharp] has *diazepam until Sun. pm.* There did not appear to be any attempt made to verify this by the clinicians involved. Mr Cox stated he was concerned Ms Sharp may experience some level of withdrawal from Benzodiazepines, but did not verify her access or alert Murnong Clinic to his concerns.

37. Mental health staff working in crisis assessment teams and community based teams often have access to taxi vouchers for transport to and from offices, emergency departments or to a patient's home. It is apparently up to individual clinicians to decide who to arrange transport for and a clinician would usually be required to assess a patient as vulnerable, or are unable to arrange own transport. It seems that in this case, Mr Cox made his decision in the absence of any formal assessment of risk or mental state of Ms Sharp and an appropriate discharge plan.

Post Mortem Examination

38. An autopsy was performed by Dr Shelley Robertson, Senior Forensic Pathologist with the Victorian Institute of Forensic Medicine. Dr Robertson formulated the cause of death and in her report and commented:

> "This 34 year old female, Lisa Sharp, died by hanging with a ligature encircling the neck. Toxicological analysis showed a blood ethanol level of 0.05g/100ml and the presence of benzodiazepines might have produced an alteration in mental state, thus contributing to death."

Finding

It is apparent that Ms Sharp who had been subject to a Community Treatment Order unfortunately died from hanging. The investigation and inquest revealed deficiencies in the care and management she received prior to her death. She was left anxious and distressed in the lead up and after a court hearing relating to her dearly loved children.

When she was eventually seen by a psychiatric nurse a couple of days later after an attempted suicide and ambulance transfer to Maroondah Hospital she was inadequately assessed and treated.

It is a great pity that she did not receive the appropriate support, assessment and treatment she so desperately needed and deserved.

RECOMMENDATIONS:
Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. To improve the safety of patients with mental health issues who are in crisis, Eastern Health Mental Health Services should review the current guidelines for patients who present to the organisation's Emergency Departments to:
   A. comply with the Department of Health 2010 Working with the suicidal person Clinical practice guidelines for emergency departments and mental health services. Particular emphasis should be given to ensuring that the assessment of patient risk of self-harm and completion of a mental state examination are identified and clearly articulated; and

   B. develop clear guidelines for the timely review by community mental health services for patients who have undergone assessment and are consequently discharged.

2. To improve the safety and engagement of the patient, and to mitigate the risk of clinical deterioration, Eastern Health Mental Health Services should review current guidelines regarding how best to support a case managed patient on a Community Treatment Order when there are custody issues pertaining to the patient.

I also direct that this finding be distributed to Department of Human Services and Department of Health, Mental Health Drugs and Regions Division for their information.

Signature:

Heather Spooner
Coroner

16th August, 2011

DISTRIBUTION:
Dr Ruth Vine
The Chief Psychiatrist, Level 17, 50 Lonsdale Street, Melbourne 3000
The Chief Executive Officer, Eastern Health, 5 Arnold Street, Box Hill 3128
Ms Louise Johnson, Director - Legal Services Branch
Department of Human Services, 50 Lonsdale Street, Melbourne VIC 3000
Ms Fran Thorn, Secretary
Department of Health, 50 Lonsdale Street, Melbourne VIC 3000